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1. As stipulated in 12 VAC 30-70-231, operating payments for DRG cases that are not transfer cases shall be determined on the basis of a hospital specific operating rate per case times the relative weight of the DRG to which the case is assigned.

2. As stipulated in 12 VAC 30-70-241, operating payments for per diem cases shall be determined on the basis of a hospital specific operating rate per day times the covered days for the case with the exception of payments for per diem cases in freestanding psychiatric facilities. Payments for per diem cases in freestanding psychiatric facilities licensed as hospitals shall be determined on the basis of a hospital specific rate per day that represents an all-inclusive payment for operating and capital costs.

3. As stipulated in 12 VAC 30-70-251, operating payments for transfer cases shall be determined as follows: (i) the transferring hospital shall receive an operating per diem payment, not to exceed the DRG operating payment that would have otherwise been made and (ii) the final discharging hospital shall receive the full DRG operating payment.

4. As stipulated in 12 VAC 30-70-261, additional operating payments shall be made for outlier cases. These additional payments shall be added to the operating payments determined in subdivisions 1 and 3 of this subsection.

5. As stipulated in 12 VAC 30-70-271, payments for capital costs shall be made on an allowable cost basis.

6. As stipulated in 12 VAC 30-70-281, payments for direct medical education costs shall be made on an allowable cost basis.

7. As stipulated in 12 VAC 30-70-291, payments for indirect medical education costs shall be made quarterly on a prospective basis.

8. As stipulated in 12 VAC 30-70-301, payments to hospitals that qualify as disproportionate share hospitals shall be made quarterly on a prospective basis.

C. The terms used in this article shall be defined as provided in this subsection:

"Base year" means the state fiscal year for which data is used to establish the DRG relative weights, the hospital case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is re-based and re-calibrated. In subsequent re-basing, the Commonwealth shall notify affected providers of the base year to be used in this calculation.

"Base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages from the claims data and places all hospitals on a comparable basis.

"Base year standardized costs per day" reflects the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages from the claims data and places all hospitals on a comparable basis. Base

year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in this subsection under the definition of "per diem cases."

"Cost" means allowable cost as defined in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130) and by Medicare principles of reimbursement.

"Disproportionate share hospital" means a hospital that meets the following criteria:

1. A Medicaid utilization rate in excess of 15%, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. Number 2 of this definition does not apply to a hospital:

   a. At which the inpatients are predominantly individuals under 18 years of age; or

   b. Which does not offer non-emergency obstetric services as of December 21, 1987.

"DRG cases" means medical/surgical cases subject to payment on the basis of DRGs. DRG cases do not include per diem cases.

"DRG relative weight" means the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

"Groupable cases" means DRG cases having coding data of sufficient quality to support DRG assignment.

"Hospital case-mix index" means the weighted average DRG relative weight for all cases occurring at that hospital.

"Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

"Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the Federal Register by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

"Operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. The operating cost-to-charge ratio shall be calculated using data from cost reports from hospital fiscal years ending in the state fiscal year used as the base year.

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"Outlier adjustment factor" means a fixed factor published annually in the Federal Register by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

"Outlier cases" means those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

"Outlier operating fixed loss threshold" means a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1% of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

"Per diem cases" means cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

"Psychiatric cases" means cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

"Psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital means the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from psychiatric DPUs.

"Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Rehabilitation operating cost-to-charge ratio" for a rehabilitation unit or hospital means the provider's operating costs divided by the provider's charges. In the base year, this ratio shall be calculated as described in the definition of "operating cost-to-charge ratio" in this subsection, using data from rehabilitation units or hospitals.

"Statewide average labor portion of operating costs" means a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the Virginia Health Information (VHI), or its successor.

"Transfer cases" means DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute

care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

"Type One" hospitals means those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals means all other hospitals.

"Ungroupable cases" means cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	Source
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file

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Total charges for each freestanding psychiatric case	Medicare cost reports
Total number of psychiatric days for each freestanding psychiatric hospital	Medicare cost reports
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	Medicare cost reports
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Cost report file
Rehabilitation cost-to-charge ratio for each rehabilitation unit or hospital	Cost report file
Statewide average labor portion of operating costs	VHI
Medicare wage index for each hospital	Federal Register
Medicare geographic adjustment factor for each hospital	Federal Register
Outlier operating fixed loss threshold	Claims History File
Outlier adjustment factor	Federal Register

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12 VAC 30-70-230. Repealed.

12 VAC 30-70-231. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the DRG relative weight, as determined in 12 VAC 30-70-381.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-251.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

12 VAC 30-70-240. Repealed.

12 VAC 30-70-241. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-321, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-321, times the covered days for the case.

12 VAC 30-70-250. Repealed.

12 VAC 30-70-251. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-231, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-231. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-231. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-261, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRG 456, 639, or 640 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment..

2. Cases transferred to or from a psychiatric or rehabilitation DPU of a general acute care hospital, a freestanding psychiatric facility licensed as a hospital, or a rehabilitation hospital shall not be treated as transfer cases.

12 VAC 30-70-260. Repealed.

12 VAC 30-70-261. Outlier operating payment.

A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12 VAC 30-70-231 and 12 VAC 30-70-251. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows:

1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221, times the adjustment factor specified in 12 VAC 30-70-331 B.

2. The adjusted outlier operating fixed loss threshold shall be calculated as follows:

a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the nonlabor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold.

b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage adjusted labor portion of the outlier operating fixed loss threshold.

c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the nonlabor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold.

3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12 VAC 30-70-331 B plus the hospital's operating payment for the case, as determined in 12 VAC 30-70-231 or 12 VAC 30-70-251.

4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor.

B. An illustration of the above methodology is found in 12 VAC 30-70-500.

C. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculated so as to

result in an expenditure for outlier operating payments equal to 5.1% of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Repealed.

12 VAC 30-70-271. Payment for capital costs.

A. Capital costs shall continue to be paid on an allowable cost basis and settled at the hospital's fiscal year end, following the methodology described in Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. The exception to the policy in subsection A of this section is that the hospital specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-321 B, shall be an all-inclusive payment for operating and capital costs.

C. Until prospective payment for capital costs is implemented, the provisions of 12 VAC 30-70-70 regarding recapture of depreciation shall remain in effect.

12 VAC 30-70-280. Repealed.

12 VAC 30-70-281. Payment for direct medical education costs.

A. Direct medical education shall continue to be paid on an allowable cost basis. Payments for direct medical education costs shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for direct medical education (DMedEd) costs shall be the sum of the fee-for-service DMedEd payment and the managed care DMedEd payment. Fee-for-service DMedEd payment is the ratio of Medicaid inpatient costs to total allowable costs, times total DMedEd costs. Managed care DMedEd payment is equal to the managed care days times the ratio of fee-for-service DMedEd payments to fee-for-service days.

C. Direct medical education shall not be a reimbursable cost in freestanding psychiatric facilities licensed as hospitals.

12 VAC 30-70-290. Repealed.

12 VAC 30-70-291. Payment for indirect medical education costs.

A. Hospitals shall be eligible to receive payments for indirect medical education. These payments recognize the increased use of ancillary services associated with the educational process and the higher case-mix intensity of teaching hospitals. The payments for indirect medical education shall be made in estimated quarterly lump sum amounts and settled at the hospital's fiscal year end.

B. Final payment for IME shall be determined as follows:

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1. Type One hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type One Hospitals $= [1.89 \times ((1 + r)^{0.405} - 1)]$

2. Type Two hospitals shall receive an IME payment equal to the hospital's Medicaid operating reimbursement times an IME percentage determined as follows:

IME Percentage for Type Two Hospitals $= [1.89 \times ((1 + r)^{0.405} - 1)] \times 0.4043$

In both equations, r is the ratio of full-time equivalent residents to staffed beds, excluding nursery beds. The IME payment shall be calculated each year using the most recent reliable data regarding the number of full-time equivalent residents and the number of staffed beds, excluding nursery beds.

C. An additional IME payment shall be made for inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers. This payment shall be equal to the hospital's hospital specific operating rate per case, as determined in 12 VAC 30-70-311, times the hospital's HMO paid discharges times the hospital's IME percentage, as determined in subsection B of this section.

12 VAC 30-70-300. Repealed.

12 VAC 30-70-301. Payment to disproportionate share hospitals.

A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section.

B. Hospitals qualifying under the 15% inpatient Medicaid utilization percentage shall receive a DSH payment based on the hospital's type and the hospital's Medicaid utilization percentage.

1. Type One hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times 17, times the hospital's Medicaid operating reimbursement, times 1.4433.

2. Type Two hospitals shall receive a DSH payment equal to the sum of (i) the hospital's Medicaid utilization percentage in excess of 10.5%, times the hospital's Medicaid operating reimbursement, times 1.2074 and (ii) the hospital's Medicaid utilization percentage in excess of 21%, times the hospital's Medicaid operating reimbursement, times 1.2074.

C. Hospitals qualifying under the 25% low-income patient utilization rate shall receive a DSH payment based on the hospital's type and the hospital's low-income utilization rate.

1. Type One hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times 17, times the hospital's Medicaid operating reimbursement.

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2. Type Two hospitals shall receive a DSH payment equal to the product of the hospital's low-income utilization in excess of 25%, times the hospital's Medicaid operating reimbursement.

3. Calculation of a hospital's low-income patient utilization percentage is defined in 42 USC § 1396r-4(b)(3).

D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 §13621. A DSH payment during a fiscal year shall not exceed the sum of:

1. Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year. Costs and payments for Medicaid recipients enrolled in capitated managed care programs shall be considered Medicaid costs and payments for the purposes of this section.

2. Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

E. Each hospital's eligibility for DSH payment and the amount of the DSH payment shall be calculated at the time of each rebasing using the most recent reliable utilization data and projected operating reimbursement data available. The utilization data used to determine eligibility for DSH payment and the amount of the DSH payment shall include days for Medicaid recipients enrolled in capitated managed care programs. In years when DSH payments are not rebased in the way described above, the previous year's amounts shall be adjusted for inflation.

1. Each hospital with a Medicaid-recognized Neonatal Intensive Care Unit (NICU), a unit having had a unique NICU operating cost limit under subdivision 6 of 12 VAC 30-70-50, shall have its DSH payment calculated separately for the NICU and for the remainder of the hospital as if the two were separate and distinct providers. This calculation shall follow the methodology provided in 12 VAC 30-70-301.

2. For freestanding psychiatric facilities licensed as hospitals, DSH payment shall be based on the most recently settled Medicare cost report available before the beginning of the state fiscal year for which a payment is being calculated.

12 VAC 30-70-310. Repealed.

12 VAC 30-70-311. Hospital specific operating rate per case.

The hospital specific operating rate per case shall be equal to the labor portion of the statewide operating rate per case, as determined in 12 VAC 30-70-331, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per case.

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12 VAC 30-70-320. Repealed.

12 VAC 30-70-321. Hospital specific operating rate per day.

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12 VAC 30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.

C. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases.

D. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.

E. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report .

12 VAC 30-70-330. Repealed.

12 VAC 30-70-331. Statewide operating rate per case.

A. The statewide operating rate per case shall be equal to the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor shall be determined separately for Type One and Type Two hospitals and shall be the ratio of the following two numbers:

1. The numerator of the factor is the aggregate total Medicaid operating payments to affected hospitals in hospital fiscal years ending in the base year.

2. The denominator of the factor is the aggregate total Medicaid allowable operating cost as determined from settled cost reports from the same hospitals in the same year.

12 VAC 30-70-340. Repealed.

12 VAC 30-70-341. Statewide operating rate per day.

A. The statewide operating rate per day shall be equal to the base year standardized operating costs per day, as determined in subsection B of 12 VAC 30-70-371, times the inflation values specified in 12 VAC 30-70-351 times the adjustment factor specified in subsection B of this section.

B. The adjustment factor for acute care psychiatric cases and rehabilitation cases shall be the one specified in subsection B of 12 VAC 30-70-331.

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12 VAC 30-70-350. Repealed.

12 VAC 30-70-351. Updating rates for inflation.

Each July, the DRI-Virginia moving average values as compiled and published by DRI/McGraw-Hill under contract with the department shall be used to update the base year standardized operating costs per case, as determined in 12 VAC 30-70-361, and the base year standardized operating costs per day, as determined in 12 VAC 30-70-371, to the midpoint of the upcoming state fiscal year. The most current table available prior to the effective date of the new rates shall be used to inflate base year amounts to the upcoming rate year. Thus, corrections made by DRI/McGraw-Hill in the moving averages that were used to update rates for previous state fiscal years shall be automatically incorporated into the moving averages that are being used to update rates for the upcoming state fiscal year.

12 VAC 30-70-360. Repealed.

12 VAC 30-70-361. Base year standardized operating costs per case.

A. For the purposes of calculating the base year standardized operating costs per case, base year claims data for all DRG cases, including outlier cases, shall be used. Base year claims data for per diem cases shall not be used. Separate base year standardized operating costs per case shall be calculated for Type One and Type Two hospitals. In calculating the base year standardized operating costs per case, a transfer case shall be counted as a fraction of a case based on the ratio of its length of stay to the arithmetic mean length of stay for cases assigned to the same DRG as the transfer case.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per case:

1. The operating costs for each DRG case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each DRG case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The case-mix neutral standardized operating costs for each DRG case shall be calculated by dividing the standardized operating costs for the case by the hospital's case-mix index.

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4. The base year standardized operating costs per case shall be calculated by summing the case-mix neutral standardized operating costs for all DRG cases and dividing by the total number of DRG cases.

5. The base year standardized operating costs per case shall be reduced by 5.1% to create a pool for outlier operating payments. Eligibility for outlier operating payments and the amount of the outlier operating payments shall be determined in accordance with 12 VAC 30-70-261.

C. Because the current cost report format does not separately identify psychiatric costs, claims data shall be used to calculate the base year standardized operating costs per case, as well as the base year standardized operating costs per day described in 12 VAC 30-70-321. At such time as the cost report permits the separate identification of psychiatric costs and the DRG payment system is recalibrated and rebased, cost report data shall be used to calculate the base year standardized operating costs per case and base year standardized operating costs per day.

12 VAC 30-70-370. Repealed.

12 VAC 30-70-371. Base year standardized operating costs per day.

A. For the purpose of calculating the base year standardized operating costs per day, base year claims data for per diem cases shall be used. Base year claims data for DRG cases shall not be used. Separate base year standardized operating costs per day shall be calculated for Type One and Type Two hospitals.

B. Using the data elements identified in subsection E of 12 VAC 30-70-221, the following methodology shall be used to calculate the base year standardized operating costs per day:

1. The operating costs for each per diem case shall be calculated by multiplying the hospital's total charges for the case by the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-221.

2. The standardized operating costs for each per diem case shall be calculated as follows:

a. The operating costs shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of operating costs. Hence, the nonlabor portion of operating costs shall constitute one minus the statewide average labor portion of operating costs times the operating costs.

b. The labor portion of operating costs shall be divided by the hospital's Medicare wage index, yielding the standardized labor portion of operating costs.

c. The standardized labor portion of operating costs shall be added to the nonlabor portion of operating costs, yielding standardized operating costs.

3. The base year standardized operating costs per day for acute care psychiatric cases shall be calculated by summing the standardized operating costs for acute care psychiatric cases and dividing by the total number of acute care psychiatric days. This calculation shall be repeated separately for freestanding psychiatric cases and rehabilitation cases.